Healthy Columbia Willamette Collaborative Frequently Asked Questions

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1. What is a Community Health Needs Assessment? A community health needs assessment (CHNA) is an analysis of community health needs and assets. It is performed by examining population health data and seeking community input.

The federal Affordable Care Act, Section 501(r)(3) requires tax-exempt hospital facilities to conduct a Community Health Needs Assessment (CHNA) at minimum once every three years, effective for tax years beginning after March 2012. Through the Public Health Accreditation Board, local public health agencies now may achieve accreditation by meeting a set of standards. As part of the standards, they must complete a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP). Coordinated Care Organizations (CCO) serving the three counties in Oregon are required to meet Oregon Administrative Rules and Oregon Health Authority guidelines pertaining to the development of a CHA and a CHIP.

2. What is the Healthy Columbia Willamette Collaborative?

The Healthy Columbia Willamette Collaborative (HCWC) is a large public-private partnership among 15 hospitals, four local public health agencies and two Coordinated Care Organizations in Clackamas, Multnomah and Washington Counties of Oregon and Clark County, Washington.

Members include: Adventist Medical Center, Clackamas County Public Health Division, Clark County Public Health, FamilyCare, Health Share of Oregon, Kaiser Sunnyside Medical Center, Kaiser Westside Medical Center, Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, Legacy Meridian Park Medical Center Legacy Mount Hood Medical Center, Legacy Salmon Creek Medical Center, Multnomah County Health Department, Oregon Health & Science University, PeaceHealth Southwest Medical Center, Providence Milwaukie Hospital, Providence Portland Medical Center, Providence St. Vincent Medical Center, Providence Willamette Falls Medical Center, Tuality Healthcare, and Washington County Public Health Division.

3. How did the project originate?

In 2010, local health care and public health leaders began to discuss the upcoming need for several community health assessments and health improvement plans within our region in response to the Affordable Care Act and Public Health Accreditation. They recognized that the most efficient and effective approach would be to create a work group responsible for conducting a region-wide community health assessment. With start-up assistance from the Oregon Association of Hospitals and Health Systems, Healthy Columbia Willamette Collaborative leadership group was developed.

In June 2013, FamilyCare and Health Share of Oregon, the Coordinated Care Organizations serving the three counties in Oregon, joined HCWC in response to Oregon Administrative Rules and Oregon Health Authority guidelines pertaining to community health assessment and health improvement plans.

4. What are the vision and purpose of the Healthy Columbia Willamette Collaborative?

Assessing community needs, improving health

HCWC will conduct a community health needs assessment which informs health improvement plans of the participating hospitals, Coordinated Care Organizations (CCOs), and local public health authorities. This assessment will be conducted every three years, with the next assessment to be completed July 2019.

This unified and comprehensive approach will assess the health needs of all community members to inform the health improvement plans of the participating organizations. It aims to eliminate duplicative efforts; prioritize needs, and enable collaborative efforts in implementing and tracking improvement activities. This collaborative approach enables the creation of an effective, sustainable process; stronger relationships between communities, CCOs, hospitals and public health; meaningful community health needs assessments; and results in a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and wellbeing of our communities.

5. What is the assessment model being used by HCWC?

HCWC is using a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) assessment model. The MAPP model uses health data and community input to identify the most important community health issues. This assessment will be conducted every three years. The modified MAPP model used by HCWC includes four major assessments. These assessments were conducted between August 2012 and April 2013 to complete the 2013 CHNA. The process was further refined for the second assessment completed in July 2016.

The Community Themes and Strengths Assessment

This first assessment involved reviewing 62 community engagement projects that had been conducted in the four county region since 2009. Qualitative responses from community members participating in 62 projects were analyzed for themes about health issues they identified as the most significant to the community, their families, and themselves. This assessment has been refined for HCWC's second assessment completed in July 2016.

The Health Status Assessment

The second assessment was conducted by epidemiologists from the four local public health agencies with representatives from two hospital systems acting in an advisory capacity. This work group systematically analyzed quantitative population health-related behavior and outcome data to identify important health issues affecting each of the four counties as well as the region. More than 120 health indicators (mortality, morbidity and health behaviors) were examined. Currently, social determinants of health and additional indicators requested during feedback from the 2013 CHNA are being developed for inclusion in the next assessment.

The Local Community Health System Assessment & Forces of Change Assessment

The third and fourth assessments were combined, and involved interviewing and surveying 126 stakeholders. This assessment was designed to solicit stakeholder feedback on the health issues resulting from the first two assessments listed above. Stakeholders were asked to add and prioritize health issues they thought should be on the list, as well as describe their organizations' capacity to address these health issues. This assessment was further refined for HCWC's second assessment, completed in July 2016.

Community Listening Sessions

The next phase is not a formal MAPP component, but was added to ensure the findings from the four assessments resonated with the local community. Twenty-nine community listening sessions were held with uninsured and/or low-income community members living in Clackamas, Clark, Multnomah and Washington counties. More than 100 organizations and local businesses helped recruit for these discussions so that members of a variety of culturally identified communities and geographic communities would be reached. In all, 364 individuals participated. During these small group (10-15 participants) discussions, facilitators asked community members to draw a picture of their community and then speak to a set of open-ended questions. The questions were:

1. What makes a healthy community?
2. How can you tell when your community is healthy?
3. What's working? What are the resources that currently help your community to be healthy?
4. What's needed? What more could be done to help your community be healthy?

These open-ended questions allowed community members to express their views without specific prompts.

6. How are the findings from the assessment being used by HCWC?

HCWC Member Organization Community Health Needs Assessments and Community Health Improvement Plans

HCWC member organizations have incorporated HCWC's assessment into their individual CHNAs and Community Health Improvement Plans (CHIPs).

HCWC Issue-Specific Workgroups

Based on the 2013 CHNA results, follow-up with content experts, and prioritization within HCWC leadership, HCWC member organizations committed to work collectively on two community health improvement strategies as part of the first cycle. These strategies included:

- Promote breastfeeding/breast milk support
- Prevent prescription opioid misuse

Community health improvement workgroups comprised of content experts, were formed to develop work plans and evaluation protocols for both community health improvement strategy areas starting in the spring of 2014.

7. How are community members involved?

In an effort to expand community voice and increase meaningful engagement with marginalized and underrepresented populations for the 2016 community health needs assessment (CHNA), the HCWC Leadership Group created a Community Engagement Workgroup (CEW). The CEW was tasked with designing and implementing a community outreach strategy to ensure the voices of community members in the four-county region were collected and incorporated into the final report. The CEW included staff from HCWC member organizations working with vulnerable populations, as well as community members and stakeholders from community organizations. The goals of the group were to augment community voice in the CHNA, prevent duplicative efforts, respect community member contributions, and build upon existing community engagement work from local organizations and government programs. Over the course of 18 months and approximately 30 meetings, the CEW created and promoted an online survey; planned and executed 29 listening sessions; helped analyze data from the listening sessions, survey, and inventory of community engagement projects; and blended data from the three tools to create a list of priority needs in the region.

HCWC continues to convene a Community Engagement Work Group, comprised of community members, equity experts, and HCWC members. This work group will continue to guide development of data-collection tools, outreach efforts, and the application of an equity lens so that community input will play a larger role in this next assessment. All HCWC member organizations are committed to this work and have agreed to contribute in-kind and financial resources to increase community engagement.

8. Is HCWC focusing on health disparities?

The Healthy Columbia Willamette Collaborative is committed to addressing health disparities and working with communities who are experiencing them. All phases of community engagement completed to date have built on information learned from vulnerable communities and through epidemiological study specifically looking for health indicators with racial/ethnic and/or gender health disparities.

Workgroups for promoting breastfeeding/breast milk support and preventing prescription opioid misuse included community stakeholders to ensure that strategies developed take into account the region's most vulnerable communities and are in line with community needs and efforts already taking place.

For the second assessment, racial/ethnic and/or gender health disparities will continue to be part of the Health Status Assessment criteria.

The Community Engagement Work Group was established to learn more about populations with disparate outcomes in the HCWC region. This work group guided data-collection tools, outreach efforts, and the application of an equity lens so that community input would play a larger role in the assessment.

9. Will the Community Health Needs Assessment report be made available?

Multiple reports detailing each assessment phase of HCWC's 2013 CHNA work can be found by clicking on the reports page of the HCWC website.

HCWC published a Progress at a Glance document in June 2015, which is also available on the reports page of the HCWC website. The second regional CHNA is available <here>.

10. Who can I contact if I would like more information about the Collaborative?

Please contact the following HCWC representatives for more information:

- Jennifer Hendrickson, HCWC Project Director, jennifer.hendrickson@q-corp.org
- Tricia Mortell, HCWC Co-Chair, tricia_mortell@co.washington.or.us
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